_____ **NEW** **Mental Retardation Community Medicaid Services** _____**REVISION**
FOR CSP YEAR **FOR CSP YEAR**

INDIVIDUAL SERVICE PLAN

Indicate Service: _____Personal Assistance Services
XXXX Respite Care

ESTIMATED DURATION: _____

Consumer:_____Medicaid Number:_____

Code: **Z9421** Provider Name:_____Provider Number:_____
Responsible Person:_____Telephone:_____

Start Date :_____ End Date: _____ Quarterly Review Dates:

CSP SELECTED GOAL/ DESIRED OUTCOME: To provide temporary care to consumer normally provided by family or primary care giver.

OBJECTIVES	TARGET DATE	ACTIVITIES/ STRATEGIES (A: Assistance, G: General Supervision)
1) Assist the consumer with personal care and daily activities. 2) Ensure the health and safety of the consumer.		Staff will provide **assistance** in the following areas (Specify): Personal Care: _____ Frequency: Monitoring Health/Physical Condition :_____ Frequency: Medication/Other Medical Needs :_____ Frequency: Meal Preparation:_____ Frequency: Housekeeping: _____ Frequency: Accompanying to Meetings and/or Appointments: _____ Frequency: Participation in Recreational Activities:_____ Frequency: Other: _____ Staff will provide **supervision** in the following areas (Specify): Personal Care: _____ Frequency: Monitoring Health/Physical Condition:_____ Frequency: Medication/Other Medical Needs:_____ Frequency: Meal Preparation:_____ Frequency: Housekeeping: _____ Frequency: Supervision to Insure Safety:_____ Frequency: Participation in Recreational Activities:_____ Frequency: Other:_____

Consumer:_____Service:__**Respite Care**___ Start Date:____

CSP SELECTED GOAL/ DESIRED OUTCOME: To provide temporary care to consumer normally provided by family or primary care giver.		
OBJECTIVES	TARGET DATE	ACTIVITIES/ STRATEGIES (A: Assistance, G: General Supervision)
3) Complete documentation a minimum of monthly on services provided in support plan. 4) Recommend to CSB CM modifications to ISP as needed, to ensure completion of stated objectives. 5) Inform Case Manager of respite supports provided during the quarter.		Documentation will include the following: - date/supports provided; - total amount of time (in and ?ut) of service delivery. - signature of persons providing the support. - consumer's responses and satisfaction with the service provided. (Can use DMAS 90 Aide form). Forward to CSB CM as requested no later than _____ Working days following the end of the month for which the service is delivered. Advise CM on the monthly note, if services were not delivered As scheduled. Forward revised ISP to CM for approval PRIOR to Implementation. Complete written OR verbal summary of supports delivered during the quarter and forward to or advise the CSB CM as requested, no later than _____ working days following the end of the quarter (unless otherwise required by licensing or certification).

OPTIONAL FORM

Consumer:_____ Service: **RESPITE** Start Date:_____

TOTAL HOURS PER YEAR

GENERAL SCHEDULE OF SERVICES

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

NOTE: Respite Services are limited to 720 hours per year.

COMMENTS: